DSHS/Mental Health Division
PO Box 45320
Olympia WA 98504-5320

TO BE COMPLETED BY MHD
Date Application Reviewed_____
Referred to Supervisor?_____
☐ Approved ☐ Denied

Application For Peer Counselor Training

Please Type or Print Clearly – All sections must be completed for the application to be processed.

The information you provide on this page will be shared with the Mental Health Division's designated contractor, which is currently the Washington Institute for Mental Health Research and Training (WIMHRT), and unless otherwise indicated, may be shared with community partners, including the Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), the Department of Vocational Rehabilitation (DVR), and others.

Demographic Information

Applicant's Name LAST	FIRST	MIDDLE INITIAL
MAILING ADDRESS		

CITY	STATE	ZIP	COUNTY

DAYTIME TELEPHONE NUMBER	CELL NUMBER or PAGER	EMAIL ADDRESS

PRIMARY LANGUAGE SPOKEN AT HOME	OTHER LANGUAGES (including American Sign Language)

HIGHEST LEVEL OF EDUCATION COMPLETED

Washington Administrative Code (WAC) 388-866-0150

"Consumer" means:

- A person who has applied for, is eligible for or has received mental health services.
- For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

☐ *I agree that I am a "consumer" based on the definition above and I am 18 years of age or older.*

Employment

Employed ☐ Full time ☐ Part time ☐ No **Volunteer** ☐ Full time ☐ Part time ☐ No

Employer Name (For volunteer work, please provide the name of the organization.)

Title of Current Position & Length of Employment/Volunteer Work:

Briefly describe your current job duties or your activities as a volunteer:

If you earn certification as a peer counselor, do you intend to seek employment or volunteer work?

Equal Opportunity Statement

The Mental Health Division provides equal opportunity for all applicants regardless of race, color, creed, religion, national origin, sexual orientation, veteran status, gender, disability status or age.

Please Read – Signature Required

- I understand that training slots are limited and therefore submission of this application does not guarantee admission.
- I understand that I must successfully pass an oral and a written exam within one year of completing the required 40-hours of classroom training and I must provide verification that I have registered as a counselor through the Department of Health prior to certification by the Mental Health Division.
- I understand that certification as a peer counselor does not guarantee employment.

Signature:	**Date:**

DSHS/Mental Health Division Supplemental Questions for Peer Counselor Training

Applicant's Name

Successful applicants will demonstrate:

- **They are well grounded in their own recovery for at least one year;**
- **Qualities of leadership, including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities.**

Please answer the following questions to demonstrate that you meet the above requirements for successful applicants.

Your answers may be typed or handwritten. Attach a separate sheet of paper if additional space is needed.

Confidentiality Statement

The information provided in the section below, Questions 1, 2, 3, and 4, will be treated as confidential and will not be shared with community partners. The information will be available to authorized personnel only.

1) Why are you applying to attend training for certification as a peer counselor? Please describe your short-term and long-term goals related to certification as a peer counselor.

2) Applicants must be well grounded in their own mental health recovery for at least one year. Have you have been in mental health recovery for at least one year?

3) Applicants must demonstrate qualities of leadership including governance, advocacy, creation, implementation or facilitation of peer-to-peer groups or activities. Describe activities you have been involved with and how you demonstrate qualities of leadership as described above.

4) Certified Peer Counselors must be willing to share their personal story of recovery to assist others. How have you shared your personal story? Include an example of a time you've shared your story for the benefit of other consumers/peers.

Remember to sign and date page 1 of the Application for Peer Counselor Training.

Return your completed application to:

DSHS/Mental Health Division
Attention: Bonnie Staples, Program Administrator
PO Box 45320
Olympia WA 98504-5320
Phone 360-902-0794 0r 1888-713-6010 Fax 360-902-0809